

Item 13e per phone 11/4/83 dad

FOR
STATE
REGISTRARZip code
21863STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

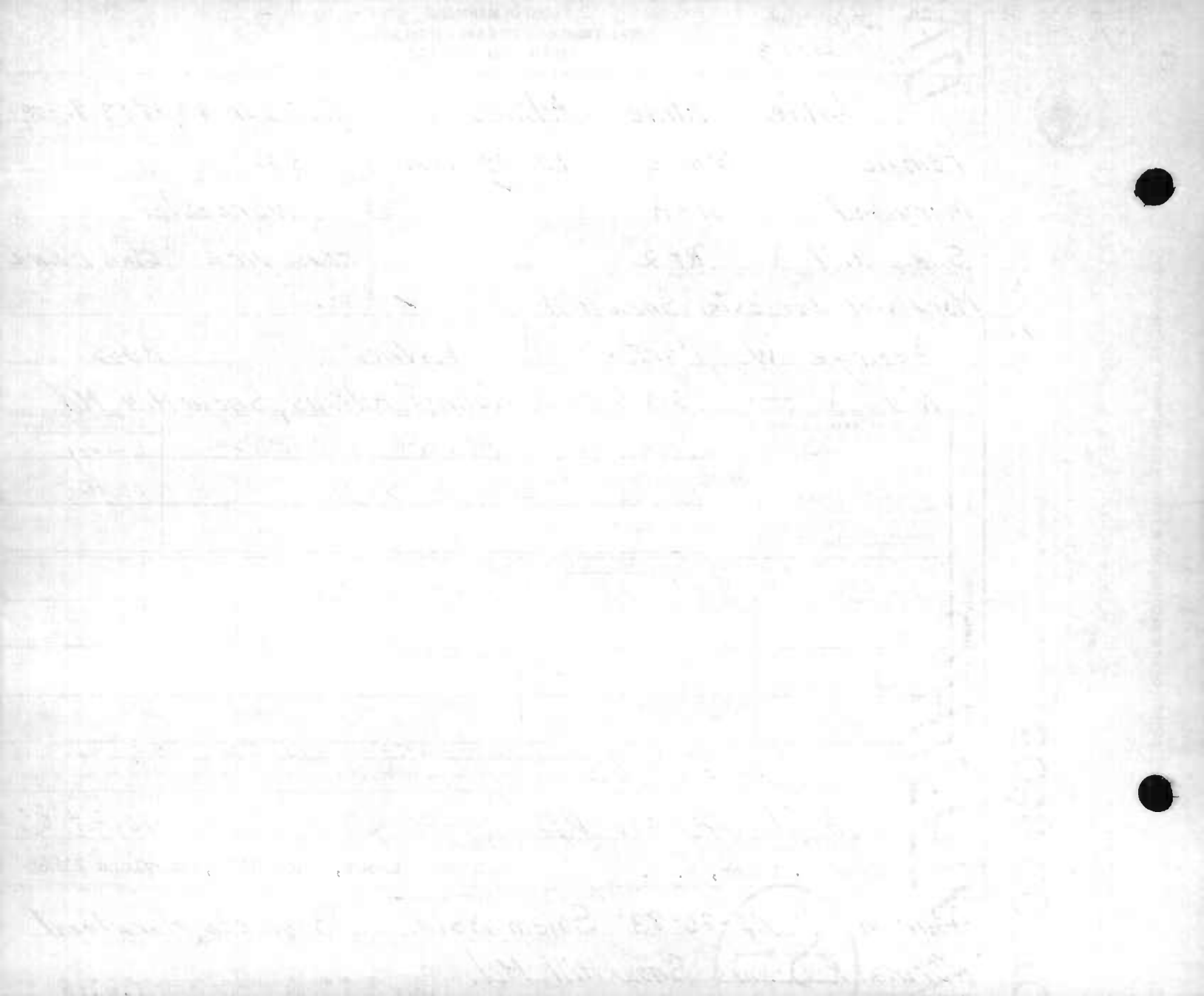
83 28434

1. DECEASED NAME (TYPE OR PRINT) Lillie Aline Adkins			2a. DATE OF DEATH MONTH DAY YEAR October 23 1983			2b. HOUR 9:30 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10-19-1901		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.			
10. CITY OR TOWN OF DEATH Snow Hill		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt 2				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Worcester		13c. CITY OR TOWN Snow Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 2 21863	
14. FATHER'S NAME FIRST MIDDLE LAST George W. Carter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lavinia Ross					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 213 74 0622		17. INFORMANT ADDRESS John J. Adkins, Snow Hill, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE CARDIAC FAILURE 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC C-V-D DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 10 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): PERICARDIAL SHOCK FROM GASTRIC HEMORRAGE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from DEC 19 54 , to 10-22 1983 , that (I) (we) lost saw the deceased alive on 10-32-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert C. LaMar, M.D.				DEGREE M.D.				22c. DATE SIGNED 10/24/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert C. LaMar, M. D.				22e. ADDRESS 104 Bay Street, Snow Hill, Maryland 21863					
23a. BURIAL, CREMATION, REMOVAL (NOTIFY) Burial		23b. DATE 10-26-83		23c. NAME OF CEMETERY Salem Meth.		23d. LOCATION CITY OR TOWN COUNTY STATE Tacomake, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Norman F. Dennis, Snow Hill, Md.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DEATH CERTIFICATE AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

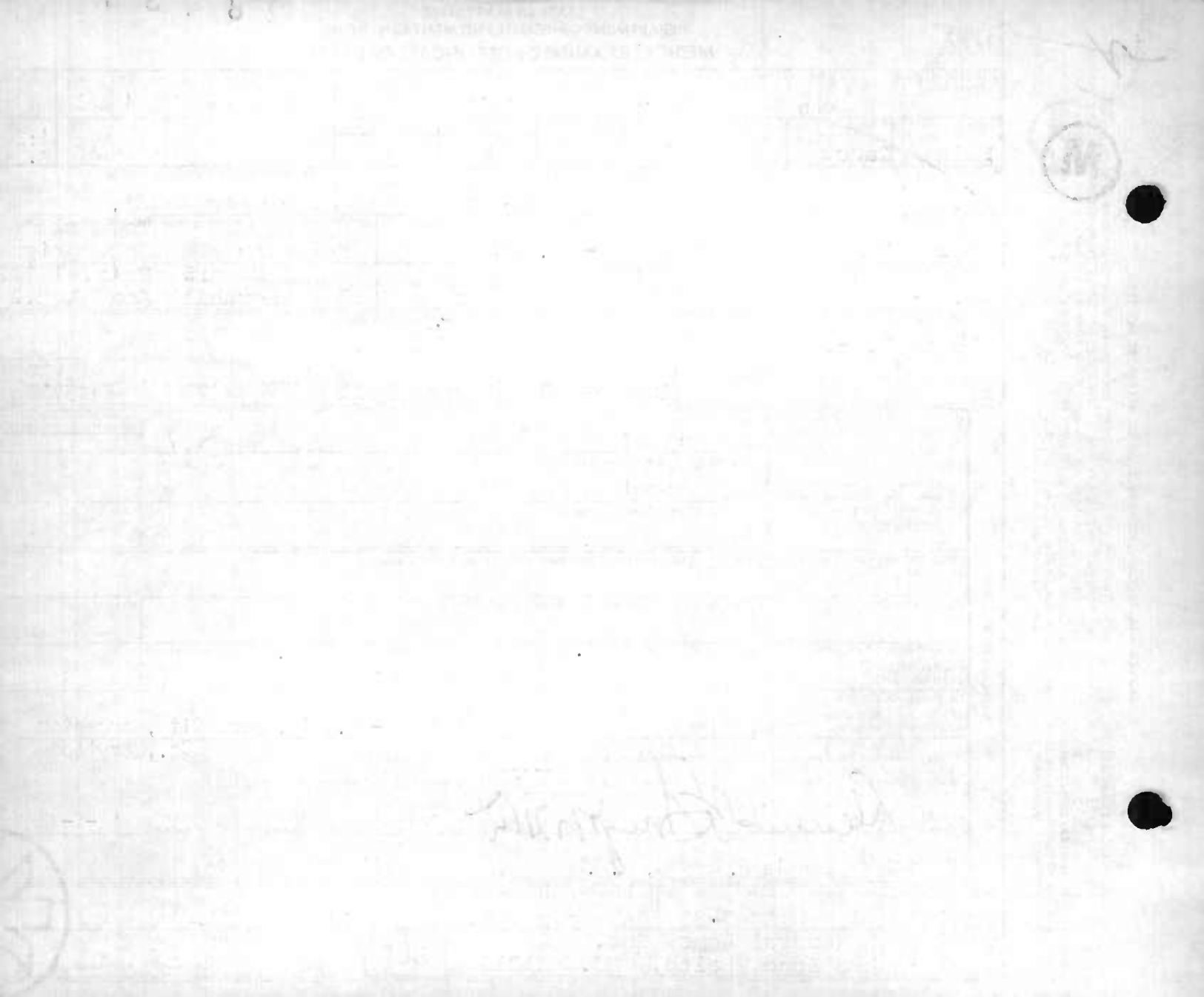
DHMH - 17
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20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John Henry Bell										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 1 1983		2b. HOUR M 1:20 P. M.			
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 8-29-1940		6. AGE (IN YEARS) LAST BIRTHDAY 43 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 4 1983		2d. HOUR P. M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester County, Md.					
10. CITY OR TOWN OF DEATH Ocean City				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frontiertown - Rt. 611				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman				12b. KIND OF BUSINESS OR INDUSTRY Enterprise			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Dela.				13b. COUNTY Newark				13c. CITY OR TOWN Newark				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1702 Thornhill Road Apt. 2	
FATHER'S NAME FIRST MIDDLE LAST Thomas H. Bell						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adele C. Tooma									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-38-1240				17. INFORMANT ADDRESS Newark Del. 1702 Thornhill Dr. 19702							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9518 IMMEDIATE CAUSE (a) Hypoxia DUE TO, OR AS A CONSEQUENCE OF (b) Acetylene Inhalation DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY (est.) HOUR A.M. MONTH DAY YEAR ? P.M. 10 1 19 83				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject inhaled fumes							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) House				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Frontiertown-Rt. 611, Ocean City, Worcester Co., Maryland							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Dennis F. Smyth				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 10-5-83			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10-7-83		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.					
24. FUNERAL HOME Scrimmick Funeral Home, Inc.						25a. DATE REC'D. BY REGISTRAR OCT 7 1983				25b. REGISTRAR'S SIGNATURE John J. Connel					
ADDRESS 3331 Brehms Lane, Balto., Md. 21213															

999999



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Virginia Brittingham Cropper			2a. DATE OF DEATH MONTH DAY YEAR 10 7 83			2b. HOUR 2 A.M.			
3. SEX female		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1 17 1909		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.			
10. CITY OR TOWN OF DEATH Ocean City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 202 12th Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY Worcester		13c. CITY OR TOWN Ocean City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 202 12th Street 21842	
14. FATHER'S NAME FIRST MIDDLE LAST RALPH BRITTINGHAM				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE BAKER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 221-16-2065		17. INFORMANT ADDRESS MRS. LUM MAYNE - OCEAN CITY					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 1991 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 19 80 to 10-7 19 83, that (1) (we) last saw the deceased alive on 8-3 19 83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) view the body after death.									
22b. SIGNATURE Steve Waters			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-7-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steve Waters			22e. ADDRESS Tenth St. Med Ctr.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10-9-83		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION CITY OR TOWN COUNTY STATE BERLIN, WOR, MD.		
24. FUNERAL DIRECTOR NAME ULLRICH F.H. BERLIN, MD.			25a. DATE REC'D. BY REGISTRAR OCT 13 1983			25b. REGISTRAR'S SIGNATURE John J. Conner			

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GLADYS H. JONES				2a. DATE OF DEATH MONTH DAY YEAR 10 16 83		2b. HOUR 10:10PM	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 25 10		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD.	
10. CITY OR TOWN OF DEATH BERLIN, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BERLIN NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Clothing	
13a. STATE Maryland				13b. COUNTY Wicomico		13c. CITY OR TOWN Willards	
14. FATHER'S NAME FIRST MIDDLE LAST George Hudson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Wilkins			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] No				16b. SOCIAL SECURITY NO. 214-03-1484		17. INFORMANT ADDRESS Robert Jones, Berlin, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Cerebro Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) as H.S. DUE TO, OR AS A CONSEQUENCE OF (c) Agony Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3m
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 19 83 to Oct 19 83 , that (I) (we) lost saw the deceased alive on Oct 16 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. J. Carter				DEGREE MD		22c. DATE SIGNED 10-17-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F.G. Arthes				22e. ADDRESS 3 Bay St Berlin 2111			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 10-19-83		23c. NAME OF CEMETERY OR CREMATORY New Hope		23d. LOCATION CITY OR TOWN COUNTY STATE Willards Wicomico MD	
24. FUNERAL DIRECTOR NAME Charles W. Harty				25. DATE REC'D. BY REGISTRAR OCT 20 1983			
25a. REGISTRAR'S SIGNATURE John G. Conner							

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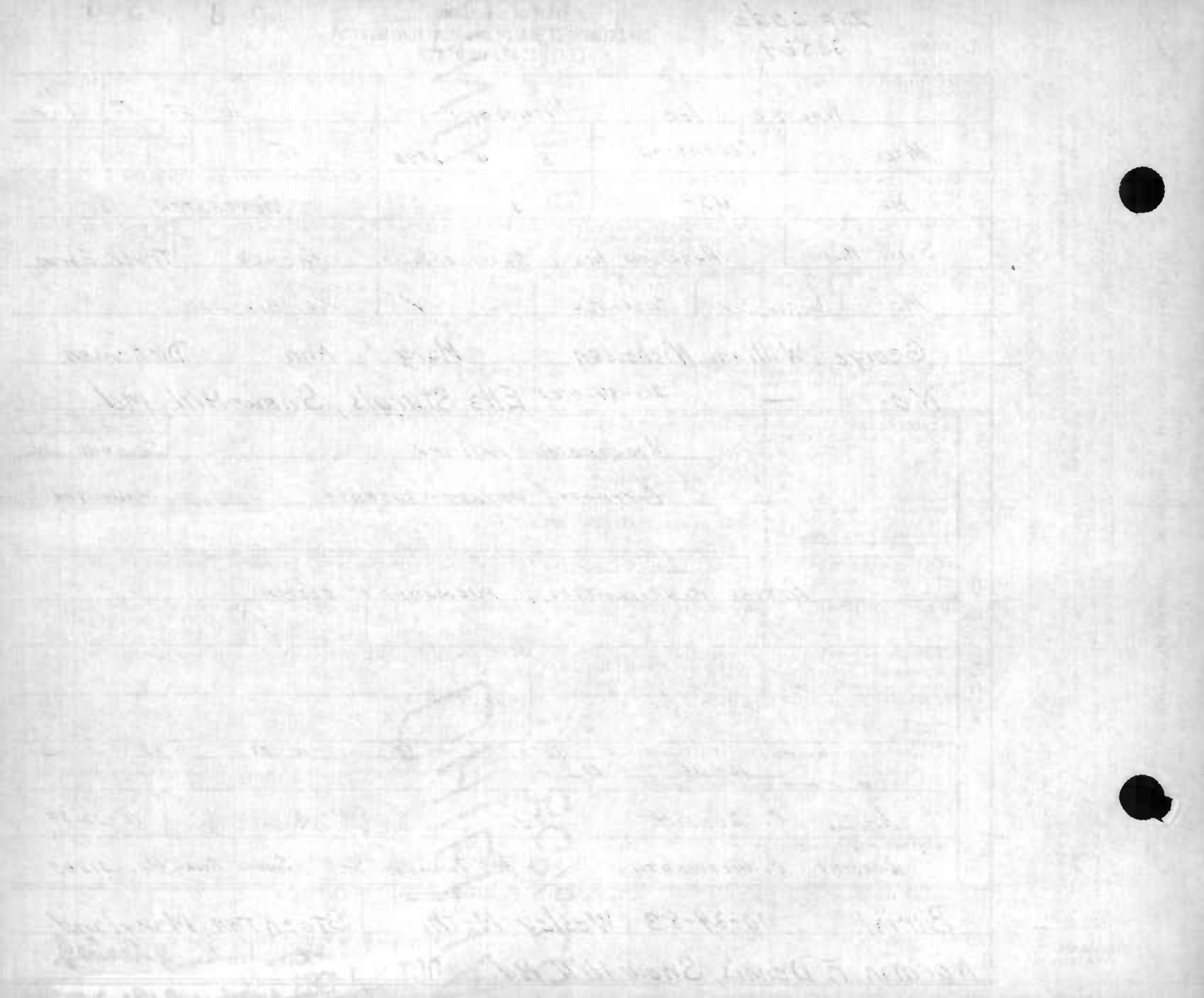
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST WALTER LEE NICHOLSON					MONTH DAY YEAR 10 27 83				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR	
MALE		CAUCASIAN		MONTH DAY YEAR 3 4 1895		88		1 30 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MD.		USA				WORCESTER Co.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
SNOW HILL		HARRISON HOUSE NURSING HOME				FARMER		TRUCK FARM	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD.		WORCESTER		STOCKTON		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		P.O. Box 223 21864	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST George William Nicholson					FIRST MIDDLE LAST Mary Ann Dickenson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
NO					219-34-4102		Ella Sturges, Snow Hill, Md.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE 4149 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SEVERAL HRS. MANY YRS.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Atrial Fibrillation, Pulmonary Edema									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (was hospitalized) attended the deceased from 10-3, 19 83, to 10-27, 19 83, that (I) (was) lost saw the deceased alive on 10-26, 19 83, and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did) <input checked="" type="checkbox"/> view the body after death.									
22b. SIGNATURE Dorothy C. Holzworth					DEGREE M.D.			22c. DATE SIGNED 10-27-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DOROTHY C. HOLZWORTH					22e. ADDRESS 309 TIMMONS ST. SNOW HILL, MD. 21863				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			10-29-83		Wesley Meth.		Stockton, Maryland		
24. FUNERAL DIRECTOR NAME					24b. ADDRESS				
Norman F. Dennis, Snow Hill, Md.					OCT 31 1983				

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

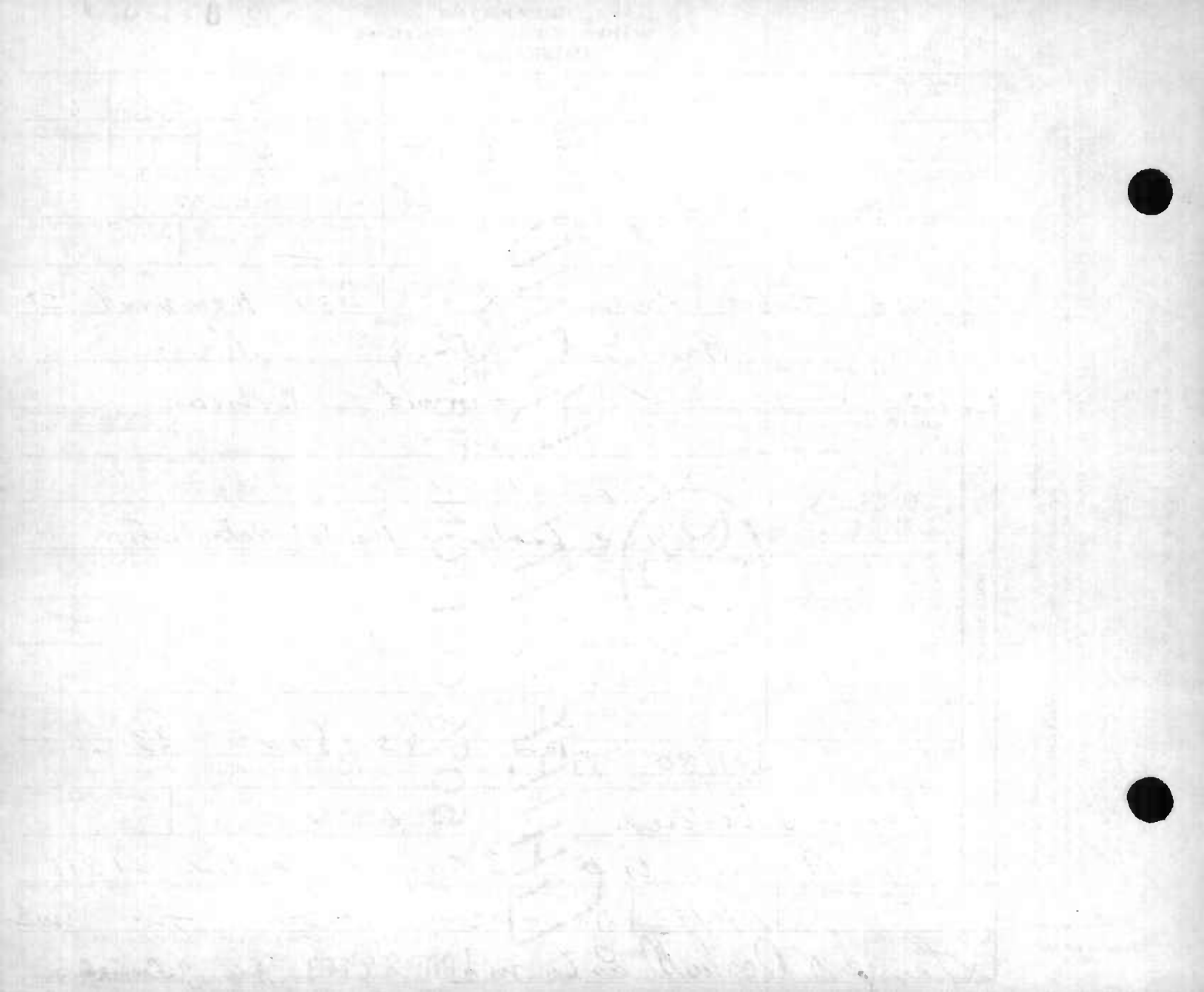
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY ALVERTA ROBERTS				2a. DATE OF DEATH MONTH DAY YEAR 10 1 83		2b. HOUR 4 am	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 7 14 1938		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 45 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER COUNTY MD.	
10. CITY OR TOWN OF DEATH BERLIN, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BERLIN NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) L		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MD		13b. COUNTY Prince Georges		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST POVRY Roberts				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Sullivan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 7		17. INFORMANT ADDRESS Edward Roberts			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA - 3190 DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration. DUE TO, OR AS A CONSEQUENCE OF (c) Tube feeding - Central Retention Firm							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3 Bay St Berlin 21811			
22a. I certify that (I) (this hospital) attended the deceased from Feb. 19 83 to Sep 83 , that (I) (we) last saw the deceased alive on Sep 30, 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE from J. Luther				DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.C. Arthes, M.D.				22e. ADDRESS 3 Bay St Berlin 21811			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 10/6/83		23c. NAME OF CEMETERY OR CREMATORY Richardson		23d. LOCATION CITY OR TOWN COUNTY STATE Easton JA MD	
24. FUNERAL DIRECTOR George A. Doswell				25a. DATE REC'D. BY REGISTRAR OCT 27 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 10 25 83			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET RUTH SENGSTACK				2b. HOUR 12:20 A.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2 25 98		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD.	
10. CITY OR TOWN OF DEATH BERLIN, MARYLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BERLIN NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spngs	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Fleming Kerfoot				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne Elizabeth Shepherd			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS George F. Sengstack Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Serum S</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>AS V.D.</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 24</u> 19 <u>83</u> to <u>Oct 25</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Oct 24</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>F. F. Arthes</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-25-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. F. Arthes				22e. ADDRESS 3 Bay St Berlin - 21811			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-27-83		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery Hagerstown Wash. Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Gerald N. Minnich Hagerstown, Maryland				25a. DATE REC'D. BY REGISTRAR OCT 31 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>	

BP

• **Answers** •

1005 Potomac St.
West in Cemetery

BP

DHMH-16 50M7/77
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME		2a. DATE OF DEATH		2b. HOUR	
FIRST	MIDDLE	MONTH	DAY	YEAR	
Pruella S. TARR		10	20	83	955 PM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female	Caucasian	MONTH	DAY	YEAR	
		05	23	00	83 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Virginia	USA			Worcester Co. MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Snow Hill	Harrison House		Housewife		Blank
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MD.	Worcester	Girdle Tree	21829		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
George Richard Young		Eliza Justice			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		213 185 252		Helen T. Rutter, Girdle Tree Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) CARDIAC ARREST					IMMEDIATE
4275 DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
RECENT ASTHMATIC BRONCHITIS					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from May 17th 19 88 to Oct. 20th 19 83, that (I) (we) last saw the deceased alive on Dec. 20th 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Dorothy C. Holzworth		M.D.		10-20-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
DOROTHY C. HOLZWORTH		309 Timmons St. Snow Hill, Md. 21863			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		10-23-83		Beth Eden	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR			
Pocomoke, Maryland		OCT 26 1983			
24. FUNERAL DIRECTOR NAME		ADDRESS		25b. REGISTRAR'S SIGNATURE	
Norman F. Dennis		Snow Hill, Md		James G. Carver	

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

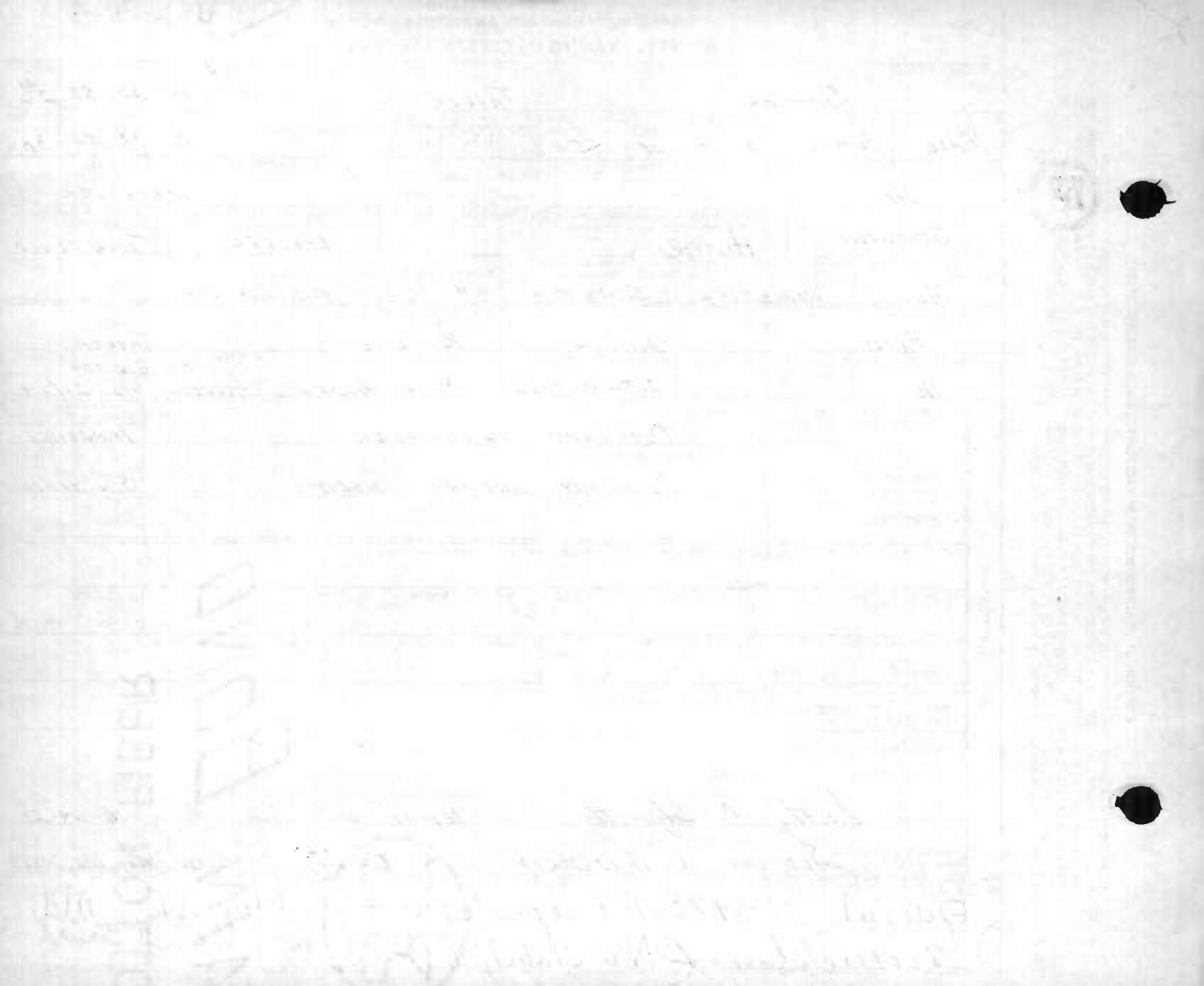
BP
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) SAMUEL TAYLOR						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 22 1983		2b. HOUR 2:30 A M	
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 2 9 31 55 YRS.	6. AGE (IN YEARS LAST BIRTHDAY) 55	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 22 1983		2d. HOUR 3 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD.			
10. CITY OR TOWN OF DEATH STOCKTON		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY TRUCK DRIVER	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD.		13b. COUNTY WORCESTER		13c. CITY OR TOWN STOCKTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS P.O. Box 275	
14. FATHER'S NAME FIRST MIDDLE LAST BARRY DOUGLAS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BEATRICE TAYLOR					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213-21-8756		17. INFORMANT ADDRESS MARY HILDEN R.O. Box 274 STOCKTON, MD. 21164			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE SEV. YEARS									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE Dorothy C. Holzworth				TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER				DATE SIGNED 10-24-83	
EXAMINER'S NAME (TYPE OR PRINT) DOROTHY C. HOLZWORTH				ADDRESS 509 TIMMONS ST. SNOW HILL, MD. 21163					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		10-29-83		Mt. Hope Cem.		Stockton Wor. Md.			
FURNERAL DIRECTOR NAME ADDRESS James D. ... New Church, Va.				23e. DATE REC'D. BY REGISTRAR NOV 3 - 1983		23f. REGISTRAR'S SIGNATURE John J. ...			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM WM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

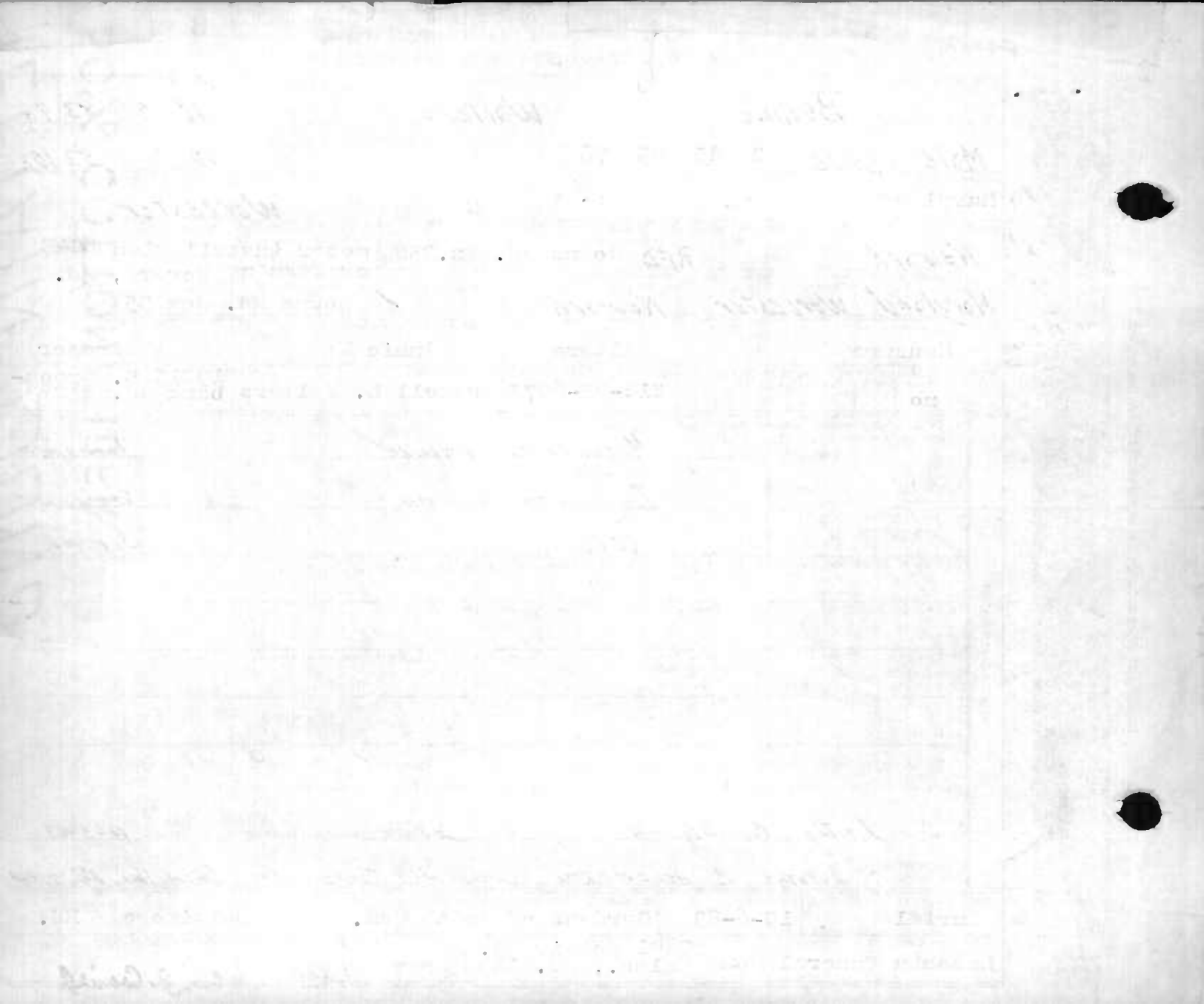
BP

DMMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		28443	
1. DECEASED NAME (TYPE OR PRINT)		20. DATE KNOWN OF DEATH	
FIRST MIDDLE LAST <i>Bennie Walters</i>		MONTH DAY YEAR <i>10-3 1983</i>	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
<i>Male</i>	<i>White</i>	MONTH DAY YEAR <i>2 25 05</i>	LAST BIRTHDAY <i>78</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Maryland</i>	<i>USA</i>		<i>Worcester</i>
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
<i>Newark</i>	<i>RFD Downs Rd. Bx. 35D</i>	<i>meter installation</i>	<i>BG&E</i>
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
<i>Maryland</i>	<i>Worcester</i>	<i>Newark</i>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	17. INFORMANT	
FIRST MIDDLE LAST <i>Mansura Walters</i>	FIRST MIDDLE LAST <i>Annie Windsor</i>	ADDRESS <i>13215 E. Green-bank Rd. 21220</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	
<i>no</i>	<i>212-05-6077</i>	<i>Russell L. Walters</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <i>MYOCARDIAL FAILURE</i>			
DUE TO, OR AS A CONSEQUENCE OF			
(b) <i>PULMONARY EDEMA</i>			
DUE TO, OR AS A CONSEQUENCE OF			
(c) <i>COPD</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY	
		HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION		CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Anthony C. Holzworth</i>		TITLE (SPECIFY) <i>DEPUTY</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>ANTHONY C. HOLZWORTH</i>		M.D. <i>DEPUTY</i> MEDICAL EXAMINER	
ADDRESS <i>509 TIMMONS ST</i>		DATE SIGNED <i>10-3-83</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
<i>Burial</i>		<i>10-6-83</i>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
<i>Gardens of Faith Cem.</i>		CITY OR TOWN COUNTY STATE <i>Baltimore Md.</i>	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
NAME ADDRESS <i>Lassahn Funeral Home 7401 Belair Rd. Balto., Md. 21236</i>		<i>OCT 7 1983</i>	
25b. REGISTRAR'S SIGNATURE			
<i>John J. Connel</i>			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NENA H Whetzel			2a. DATE OF DEATH MONTH DAY YEAR 10 18 83		2b. HOUR 10⁵⁵ P. M.				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 3 22 1987		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester Co. MD.			
10. CITY OR TOWN OF DEATH SNOW HILL		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARRISON HOUSE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY Wicomico		13c. CITY OR TOWN SALISBURY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS John B. Parsons Home 21801	
14. FATHER'S NAME FIRST MIDDLE LAST Alfred Hollingsworth			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Hoffman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 138-26-7658		17. INFORMANT ADDRESS Mrs. Ruth W. Timmons, Daughter 310 Park Row, Snow Hill, Md. 21863					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE 4149 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SEVERAL HRS. SEVERAL YRS. SEVERAL YRS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): INANITION, CHRONIC CHF, PNEUMONITIS									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the physician) attended the deceased from MAY 17TH , 19 81 , to OCT. 16TH , 19 83 , that (I) (the physician) last saw the deceased alive on OCT. 17TH , 19 83 , and that in (my) (the physician's) opinion death occurred on the date and hour and from the causes stated above, (I) (the physician) (did) (not) view the body after death.									
22b. SIGNATURE Dorothy C. Holzworth				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10-18-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DOROTHY C. HOLZWORTH				22e. ADDRESS 309 TIMMONS ST. SNOW HILL, MD. 21863					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/21/83		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Md.			
24. FUNERAL DIRECTOR NAME Holloway				ADDRESS Funeral Home, P.A. Salisbury, Md.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, and 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

